Hon. William Downing

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR KING COUNTY

WILLIAM DUSSAULT as Guardian Ad Litem for S.P., a minor, EUGENE G. PATNODE and CLARISSA A. PATNODE, husband and wife,

Plaintiff,

v.

CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER, a non-profit organization, licensed in Washington state; SELLEN CONSTRUCTION CO., INC., a Washington corporation,

Defendant.

No. 05-2-36911-6 SEA

DEFENDANT CHILDREN'S HOSPITAL AND REGIONAL MEDICAL CENTER'S INTERROGATORIES PROPOUNDED TO CLARISSA A. PATNODE

AND SUPPLEMENTAL ANSWERS THERETO

INTERROGATORY NO. 25: Describe in detail the facts upon which you rely to claim that the defendants were negligent, identifying each act or omission which you believe was wrongful and indicating what you believe should have been done under the circumstances that then existed.

ANSWER:

The defendant should have provided a properly pressured health care facility, including Operating Room #15 ("OR #15"), in accordance with the Washington Administrative Code

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when Plaintiff S.P. went in for her medical procedure. The defendant should have also provided a safe and clean heath care facility, particularly OR #15, free of aspergillus spores in accordance with Children's Hospital and Regional Medical Center ("CHRMC") Infection Control Policies and Procedures Manual (2001) (hereinafter "CHRMC Manual"). Specifically, CHRMC's Manual provides the following:

- in the HEPA filtered environment of the SCCA unit and in the Operating Room and Surgical Suite, it is expected that no Aspergillus spores will be collected.
- in other areas of the hospital, results will be compared with outside air aspergillus spore levels and will be expected to fall below that of the outside air during the same sample collection.

CHRMC/PATNODE00059. Unlike CHRMC's Manual indicating HEPA filters are utilized or to be employed in the Operating Room and Surgical Suite, CHRMC does not use HEPA filtration. See Answers to Interrogatory No. 32 and 35. Specifically, CHRMC's filters consist of 2 banks of filters and they typically are 2 inches thick with an efficiency rating of 30% and are backed up by a 95% bigh efficiency filter. *Id.* A HEPA or absolute filtration system has an efficiency rating greater or equal to 99.97% of particulates greater or equal to 0.3 microns in diameter and therefore filters aspergillus spores. Subsequently, CHRMC's filtration system does not filter aspergillus spores.

Joan Heath, Kathy Goodrich, Danielle Zerr, Steve Scheibe, Ruth Benefield, Treuman Katz, and Richard Molteni were negligent in allowing the CHRMC Manual to set forth inaccurate information particularly in light of the fact CHRMC's physicians and treating medical professionals relied on this information in providing medical care. CHRMC negligently adopted this Manual. Plaintiffs have attempted to schedule the depositions of Steve Scheibe, Ruth Benefield, Kathy Goodrich, and Richard Molteni, but CHRMC has not provided Plaintiffs with dates for these depositions. Plaintiffs anticipate that additional information as to CHRMC's negligence will be discovered during these depositions along with the discovery that CHRMC should be producing on May 4, 2007.

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CHRMC's Manual cites important medical treatises to support the adoption of measures to protect the facility's environment, but many of CHRMC infection control practitioners did not read these materials. Had the CHRMC infection control practitioners taken the time to read these materials, they should have understood the difference between a HEPA filtration system and a high efficiency filtration system. If CHRMC's infection control professionals would have understood the type of filtration system in the Operating Rooms and Surgical Suite, it would have been evident and appropriate safety measures would have been put in place to ensure a patient's safety during a surgical procedure. As this did not occur, S.P. was not in a safe and clean environment during her surgical procedure and CHRMC infection control and engineering professionals breached this standard of care.

Further, evidence of CHRMC's negligence was its failure to act on information obtained through air sample testing, which revealed higher counts of aspergillus spores inside the facility than outside. As noted earlier, there should be lower levels of aspergillus spores outside the hospital than inside it. Prior to S.P.'s infection other patients acquired nosocomial aspergillus infections. CHRMC knew, or should have known, that it had a serious infection control problem within the hospital that placed patients in danger of being exposed to aspergillus spores. Despite these red flags, CHRMC infection control practitioners and the entire ICCC failed to adequately investigate and determine the source(s) of the aspergillus spores and infections. CHRMC's negligence was compounded by the utter failure of the infection control professionals to take "routine" air samples in the OR in accordance with CHRMC's Manual during the time period preceding S.P.'s infection. See CHRMC/PATNODE00058. Plaintiffs have obtained evidence from Neudorfer Engineers, CDi Engineers, Inc., and Sellen indicating critical care areas within CHRMC were negatively pressured prior to and after S.P. acquired the aspergillus infection.

CHRMC's infection control practitioners were also negligent in their failure to provide "safety education" for construction managers/workers in addition to technical and professional staff before or during projects in accordance with CHRMC's Manual. *Id.* CHRMC did not

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adequately determine safe routes for construction workers to follow within the facility and/or enforce worker restrictions into prohibited areas such as the hospital cafeteria.

Other violations of CHRMC's Manual include but are not limited to the failure of Danielle Zerr, M.D., Chair of the ICCC, to make unscheduled inspections of construction sites. *Id.* In contravention of the Manual, Dr. Zerr had little to no oversight with the construction occurring at CHRMC. Although Joan Heath, as the Infection Control Manager, may have occasionally made unscheduled visits, construction enforcement and compliance with the CHRMC Manual was mainly left to Julie Smith. Ms. Smith lacked the experience, training and education to oversee this construction, particularly in light of the size and magnitude of the projects and the potential danger posed to patients in critical care areas. CHRMC elected not to employ an outside third-party with the expertise, knowledge and training to reasonably oversee the construction when it was presented with such an opportunity. CHRMC assumed all responsibility and risk when it made this decision.

Upon information and belief, CHRMC neither obtained a commissioning prior to beginning renovations, nor after renovations were completed in numerous areas of the hospital. In 1999 there appears to have been some commissioning completed in a very few areas, but it was not until approximately December of 2003 that CHRMC obtained a commissioning within the hospital for areas under construction such as the A and B Wings. This only occurred because it was determined that the hospital was negatively pressured. Phase III of the OR/PACU renovations started in approximately October of 2001 and were not completed until approximately May of 2002. Despite the impact of these renovations on CHRMC critical care systems, CHRMC did not obtain a commissioning. Thus, CHRMC did not know whether the HVAC system in the OR/PACU was operating as it was designed. If CHRMC would have completed a commissioning, as it should have, it would have discovered there was a problem with the HVAC systems in the OR and PACU. CHRMC infection control practitioners undertook the duty of infection control during construction. See CHRMC/PATNODE00079-

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00084. As stated in CHRMC Manual, infection control should be "involved in planning for all phases of maintenance, construction and/or renovation projects, including the design phase...." *Id.* As CHRMC failed to request a commissioning in this area, it violated the Guidelines for Design and Construction of Hospital and Health Care Facilities. See AIA Guidelines for Design and Construction of Hospital and Health Care Facilities § 5.3 (2001). This is further evidence of CHRMC's negligence.

CHRMC's Manual expressly and unequivocally provides that "[t]he most common source of filamentous fungal infections in hospitals is thought to be through dissemination of fungal spores by ventilation systems." CHRMC/Patnode00057. CHRMC's Manual warns that the most immediate danger posed to patients during construction is a compromised HVAC system. However, CHRMC did nothing to protect the HVAC systems from increased exposure to dirt and airborne pathogens such as aspergillus during outside construction.

The lack of communication, education and training by CHRMC's infection control practitioners and the ICCC to the Building and Engineering Department, and other staff was negligent. See e.g., CHRMC/PATNODE00043. For example, CHRMC's B&E should have received information about the "Hospital infection control program" from CHRMC's Manual plus annual education and training on infection control activities. The deposition testimony and interviews of fact witnesses clearly indicates this training was not done. Also, CHRMC's infection control practitioners did not make this Manual available to all hospital and contracted employees. CHRMC's Manual also states that "The Infection Control staff is responsible for developing the curriculum for nursing orientation and continuing education relating to surveillance, prevention, and control of infections." CHRMC/PATNODE00049. This also does not appear to have been done. Among CHRMC's employees there is a large minority population where English is a second language. CHRMC's infection control staff failed to verify whether all such employees understood the proper safety measures that they were being asked to complete as stated in the Manual. In general, CHRMC's B&E Departmental employees lacked

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the knowledge, education and to even be aware that the HVAC system was a common source of aspergillus infections in hospitals.

Moreover, had the CHRMC infection control practitioners fully understood the danger posed to patients by a malfunctioning HVAC system, experts in the HVAC profession could have been employed to investigate and effectively mitigate the problem and properly train the Building and Engineering ("B&E") Department. CHRMC should have had manufacturer's representatives for its facility systems provide training to the B&E Department and record those training sessions for future use. CHRMC's B&E Department does not even have Owner's Manuals to consult so it can properly maintain its HVAC systems. Providing the B&E Department with proper materials and training would have ensured that the B&E Department knew how the systems were designed to work. It would have also ensured that these systems were properly maintained. This was not done.

Rather, CHRMC allowed Leonard Blumer, who is under-qualified, to have full control and responsibility for operating and maintaining these HVAC systems. CHRMC's infection control staff and the ICCC failed to verify whether he had the knowledge, skill and education to complete this task or that documentation was available to verify function of the HVAC systems. In fact, CHRMC's infection control provided no oversight for any services that Mr. Blumer rendered on the HVAC systems. Not only did Mr. Blumer fail to correct serious HVAC malfunctions with the sheaves, bearings, belts and damper actuators, it allowed Mr. Blumer to alter the air filters CHRMC purchased. Specifically, Mr. Blumer removed the gasketing on the air filters and replaced it with his "own method" of gasketing, which left an unsealed gap. This clearly compromised CHRMC's HVAC systems and created unnecessary and unreasonable hazards for patients receiving care within the hospital.

Knowing that CHRMC's B&E employees had not been properly trained in the area of infection control and in accordance with the Manual, CHRMC's infection control practitioners and the ICCC negligently relied on the B&E Department to ensure that the HVAC system

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complied with, *inter alia*, the Washington Administrative Code. Moreover, CHRMC negligently relied on the B&E Department to determine that the HVAC systems functioned as it was designed. The B&E Department neither determined that the HVAC system met infection control standards nor that they functioned as they were designed. The evidence indicates no one at CHRMC assumed these duties. CHRMC's maintenance and care of its HVAC systems is completely reprehensible and patients such as S.P. were left to suffer the brunt of their negligence.

Plaintiffs also have evidence that CHRMC's B&E employees failed to maintain proper barrier protections when entering the ceiling. Had CHRMC's infection control practitioners engaged in proper education, training, enforcement and surveillance in accordance with the CHRMC Manual, these infection control problems would not have existed in this facility on a consistent basis.

Upon information and belief, CHRMC's infection control practitioners violated Washington's reportable diseases regulations and its own Manual by failing to report a potential outbreak of aspergillus infections. See CHRMC/PATNODE00140-00144. Similarly, CHRMC's surveillance and investigation of aspergilles infections within the facility was below the standard of care. If CHRMC would have used reasonable efforts to conduct such activities problems with the HVAC systems, among other infection control problems, would have been discovered.

Plaintiffs have given CHRMC an extension on discovery that has been served on them and this response will be supplemented within a reasonable time when such discovery is received, and when CHRMC allows Plaintiffs to inspect CHRMC premises as set forth in Request for Inspection No. 1. Further, this answer will be supplemented when CHRMC allows Plaintiffs to take the depositions of CHRMC employees that it has requested and when Plaintiffs receive documents in accordance with pending *subpoena duces tecums*. This answer will also be supplemented with expert reports pursuant to the case scheduling order.

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INTERROGATORY NO. 36: Identify all fact witnesses and expert witnesses who will testify about the basis listed in interrogatory no. 35.

ANSWER: Plaintiffs Gene and Clarissa Patnode and Plaintiff S.P. treating physicians at CHRMC. See their deposition transcripts. Plaintiffs' experts will be disclosed in accordance with the case schedule order.

ANSWERS TO INTERROGATORIES AND RESPONSES TO REQUESTS FOR PRODUCTION SUBMITTED this 27th day of Apr. 1, 2007.

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- results are communicated to stakeholders, including but not limited to Facilities management, contractors, unit managers, and hospital administration

MANAGEMENT OF AIR SAMPLING RESULTS

Standards established at Children's Hospital for acceptable sample results from ambient air are as follows:

- in the HEPA filtered environment of the SCCA unit and in the Operating Room and Surgical Suite, it is expected that no *Aspergillus* spores will be collected
- in other areas of the hospital, results will be compared with outside air *Aspergillus* spore levels and will be expected to fall below that of the outside air during the same sample collection

CONCERNING LEVELS

Depending on the location in the hospital where concerning levels are identified, infection control practitioners may:

- inspect the area where a concerning sample was obtained for issues such as:
  - air pressure gradient disturbances
  - disruption of construction barriers
  - leaking window or door seals
  - stained or water damaged ceiling tiles, flooring, or structural material
  - obvious mold or mildew growth
  - a need for environmental cleaning
- close an area to occupancy/use or delay opening an area after construction/renovation
- contact the Facilities manager, Building and Engineering director and/or construction contractor for remediation of construction barriers and air pressure gradients
- work with the unit or clinic nurse managers determine occupancy and use of a specific area while remediation occurs
- arrange for Environmental Services staff to provide thorough cleaning of a specific area
- re-sample the area after remediation activities have been completed before opening to unrestricted occupancy/use